_____ Allergy Reaction History Form

Student's Name:_____ Birth Date:_____

Parent/Guardian Name:_____ Phone:_____

Licensed Health Care Provider advising care for allergic reaction:_____

Licensed Health Care Provider's telephone number:_____

1. Briefly describe what physical symptoms occur with _____allergy:

2. When was the last time your child had a reaction to the above allergen?

3. What treatment or medication has your Licensed Health Care Provider recommended?

4. Describe any side effects your child has had from this medication.

5. Does your child understand precautions to take to avoid _____?

6. Have you and the Licensed Health Care Provider completed a treatment order form to be used in case of an allergic reaction at school? Yes___ No___ NOTE: This must be completed if a medication (oral or epipen) is needed to treat an allergic reaction.

7. Does your child use an Epipen?
   Has your child been trained to self administer the Epipen?

   Other information:_____

Parent/Guardian signature:_____ Date:_____

Form A: Dietary Prescription for **Student WITH Disability**

OSPI Child Nutrition Programs

PARENT/GUARDIAN MUST COMPLETE THIS SECTION

Student Name	Birth Date	Age	Grade	School

Parent/Guardian Name	Phone

Mailing Address	City/State/Zip

Signature of Parent/Guardian	Date

DIET ORDER – LICENSED PHYSICIAN MUST COMPLETE and SIGN THIS SECTION.

1. List student's disability: _____
   (Include life-threatening allergies which cause an immune system response to a particular food/ingredient/additive.)

2. What is the major life activity(s) affected?

3. Describe how the disability restricts student's diet:

4. List all food(s) and/or milk to be <u>omitted</u>:

5. List all food(s) and/or milk to be <u>substituted</u>:

6. List any foods that require texture modification and describe how to prepare (chop, grind fine, puree, etc.):

7. Describe any other comments about the student's eating or feeding patterns:

Signature of Licensed Physician	Date	E-mail	Phone

Printed Name of Licensed Physician	Address